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PART II - METHODS AND STANDARDS FOR ESTABLISHING PAYMENTS FOR PSYCHIATRIC INPATIENT SERVICES PROVIDED IN HOSPITALS OPERATED BY THE STATE OF WASHINGTON

A. INTRODUCTION

The State of Washington's Department of Social and Health Services through its Mental Health Division establishes systems for reimbursement of Medicaid psychiatric inpatient hospital services provided to eligible Medicaid patients in two state-operated psychiatric hospitals, Western State Hospital and Eastern State Hospital. This Part describes the reimbursement system for payment of these services. This system is used to reimburse for services provided on or after July 1, 1991.

The reimbursement systems described in this part is limited to the forgoing provider type and are not in replacement of, or substitution for, reimbursement methods for other facility types discussed in Part I of this plan attachment.

The reimbursement system's payments described in this Part are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated hospitals to provide services in conformity with applicable state and federal laws, regulations, and quality and safety standards. Payments are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient psychiatric hospital services of adequate quality.

The standards used to determine payments take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs.

The reimbursement system employs the retrospective cost reimbursement method to determine hospital payments. The following plan specifies the methods and standards used to set this payment type, including: definitions; general reimbursement policies; methods for establishing retrospective cost reimbursement; upper payment limits; and administrative policies on provider appeal procedures, uniform cost reporting requirements, and audit requirements.

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B. DEFINITIONS

The terms used in this plan are intended to have their usual meanings unless specifically defined in this section or otherwise in the plan.

1. *Department*

The Department of Social and Health Services. The department is the State of Washington's state Medicaid agency.

2. *Division*

Means the Mental Health Division of the Department.

3. *HCFA*

HCFA means the Department of Health and Human Services' Health Care Financing Administration. HCFA is the federal agency responsible for administering the Medicaid program.

4. *Hospital*

Hospital means an entity which is licensed as an psychiatric hospital in accordance with applicable State laws and regulations, and which is certified under Title XVIII of the federal Social Security Act.

5. *Medicare Adjusted Per-diem*

Means the aggregate Medicare Part A costs reported on the Medicare cost report divided by the total Medicare inpatient days reported in the same cost report. Aggregate Medicare costs exclude bad debts and incentive or penalty sums attributable to the Medicare patients reported in the cost report.

6. *Medicare Cost Report*

Means the annual cost report (Form 2552) filed each year by providers delivering Medicare services as psychiatric hospitals pursuant to 42 CFR 482.60.

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B. DEFINITIONS (cont.)

7. *MHD*

MHD means Mental Health Division of the Department.

8. *Patient Participation*

Means sums found at recipient eligibility determination to paid by the patient toward the cost of care delivered by the psychiatric hospital.

9. *Uninsured Indigent Patient*

Means an individual who receives hospital inpatient and/or outpatient services at a state psychiatric hospital and the costs of such services are subsidized by state appropriated funds because the individual has no or insufficient insurance or other resources to cover the costs of the services delivered. Medicaid patients of state psychiatric hospitals are considered fully insured through operation of retrospective reimbursement methods described in this plan part.

C. GENERAL REIMBURSEMENT POLICIES

The following section describes the general policies governing the reimbursement system.

1. Retrospective Cost Reimbursement

Payments to state psychiatric hospitals for inpatient services are made on a retrospective cost basis. Under this method Medicaid costs derived from Medicare cost principles are compared to Medicaid interim payments and any differences are paid to or collected from the provider to insure that the final payment is equal to total allowable costs.

2. Outlier Payments

The payment methods of this Part exclude outlier payments because the provider is not obliged to provide care for which reimbursement is not available.

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C. GENERAL REIMBURSEMENT POLICIES (cont.)

3. Transfer Policy

For a state psychiatric hospital transferring a recipient to another inpatient facility, the discharge day is claimed for Medicaid service. For a state psychiatric hospital receiving a recipient from another inpatient facility, the admission day is not claimed for Medicaid service.

4. Administrative Days Policy

Administrative days (42 CFR 447.2E3(b)(1)(B)) are those days of hospital stay wherein psychiatric inpatient level of care is no longer necessary, and an appropriate non-inpatient placement is not available. Administrative days are not reimbursed under the plan.

5. Medicare Crossover Policy

Medicare crossovers refer to hospital patients who are eligible for both Medicare Part A benefits and Medical Assistance. For recipients, the state considers the Medicare payment for each Medicare day to be payment in full. The state will pay the Medicare deductible and co-insurance related to the Medicare psychiatric inpatient hospital services.

In cases where the crossover recipient's Part A benefits including lifetime reserve days are exhausted or not otherwise available, the recipient will shift to full Medicaid status for all necessary future days until discharge.

6. Third-Party Liability Policy

For cases involving third-party liability (TPL), the recovery will be treated as Medicaid patient participation and subtracted from Medicaid interim reimbursement and final Medicaid settlement.

D. RETROSPECTIVE COST REIMBURSEMENT METHOD

This section describes the methodology used for retrospective cost reimbursement for state psychiatric hospitals.

Interim payments to the psychiatric hospitals are made at hospital charge rates computed pursuant to Washington Administrative Code for charges to the general public for services delivered by these hospitals. Recipient patient participation identified at eligibility determination is subtracted from aggregate monthly hospital charges and the reduced sum is paid to the provider.

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D. RETROSPECTIVE COST REIMBURSEMENT METHOD (cont.)

Total allowable cost for recipients is computed by multiplying the total Medicaid days by the Medicare Adjusted Per-diem. The product of the computation is reduced by the aggregate of patient participation, and the resulting remainder constitutes total allowable Medicaid costs.

Interim settlements are made upon the provider's completion of the Form HCFA 2552 for each fiscal year. Interim settlement is made by computing total interim payments (Medicaid days x hospital charge rate + interim ancillary charges - patient participation) for the fiscal period and comparing this amount to total allowable cost computed from Form HCFA 2552 (Medicare Adjusted Per-diem x Medicaid days - patient participation). If total allowable cost exceeds total interim payments addition payment is made to the hospital. If total interim payments exceed total allowable costs recovery of excess interim payments is made.

Final settlements are made upon the intermediary's determination of total allowable Medicare costs on Form HCFA 2552 for each fiscal year. Final settlement is made by computing total interim payments (Medicaid days x hospital charge rate + interim ancillary charges - patient participation) for the fiscal period and comparing this amount to total allowable cost computed from Form HCFA 2552 (Medicare Adjusted Per-diem x Medicaid days - patient participation). If total allowable cost exceeds total interim payments addition payment is made to the hospital. If total interim payments exceed total allowable costs recovery of excess interim payments is made. Final settlement will be adjusted for all prior interim settlements and all subsequent adjustments made due to successful appeals to Medicare Intermediary determinations.

E. DISPROPORTIONATE SHARE PAYMENTS

As required by Section 1902 (a) (13) (A) and Section 1923 (a) (1) of the Social Security Act, the Medicaid reimbursement system takes into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs by making a payment adjust for eligible hospitals. A hospital will receive the following disproportionate share hospital (DSH) payment adjustments if the hospital meets the eligible requirements.

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E. DISPROPORTIONATE SHARE PAYMENTS (cont.)

1. State psychiatric hospitals will be deemed eligible for disproportionate share payment adjustment if its Medicaid patient day utilization is at least one percent and if:

   a. The hospital's Medicaid inpatient utilization rate (as defined by Section 1923(b)(1)(A)) is at least one standard deviation above the mean state Medicaid inpatient utilization rate of hospitals receiving Medicaid payments in the State; or

   b. The hospital's low-income utilization rate (as defined by Section 1923(b)(1)(B)) exceeds 25 percent.

2. The disproportionate share adjustment for inpatient payments as determined under this section of the state plan shall be equal to the lesser of annual net costs of uncompensated services delivered to uninsured indigent patients by each facility as defined below, or each facility's proportionate residual of the annual federal allotment for disproportionate share adjustment payments after subtraction of such payments from the annual federal allotment made under provisions of Part I of this plan attachment.

   a. Annual costs of services delivered to uninsured indigent patients by a facility in a state fiscal year are the product of multiplication of aggregate facility per-diem by total annual inpatient days attributable to uninsured indigent individuals. Aggregate facility per-diem is the quotient of dividing total facility operating expenses by total facility inpatient days reported in Medicare cost report HCFA Form 2552-92 in Worksheet B-1. Total facility operating expenses are those reported in HCFA Form 255292, Worksheet G-2. Identification of uninsured indigent patients will be determined with statistical sampling methods as described in the Supplement to this Plan Part.

   Annual net costs of uncompensated services delivered to uninsured indigent patients by a facility in a state fiscal year is the residual of total aggregate annual cost of such patients as defined above, reduced by total revenue received from or on behalf of such patients. This revenue is the amount reported by the department's Office of Financial Recovery as total revenue from all sources but excluding regular Medicaid revenue and receipts of disproportionate share adjustment payments under this plan part, and also excluding Washington State general fund subsidies. Revenue received from or on behalf of uninsured indigent patients will be determined with statistical sampling methods as described in the Supplement to this Plan Part.

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E. DISPROPORTIONATE SHARE PAYMENTS (cont.)

b. For purposes of state fiscal year 1995 under the Omnibus Budget Reconciliation Act of 1993, the amounts computed as annual net costs of services delivered to uninsured indigent patients at Western State Hospital will be doubled, to compute 1995 aggregate annual cost, provided that the Governor of the State of Washington makes certification acceptable to HCFA that the minimum amount will be used for health services, and further provided that this facility is found to have rendered the greatest number of Medicaid inpatient days of all Medicaid inpatient providers in the state during state fiscal year 1994.

3. The disproportionate share adjustment payments shall be made to each hospital in two installments for each federal fiscal year, as described below.

a. The initial installment payment will be the prorated appropriated disproportionate share funding plan for each psychiatric hospital for the state fiscal year but no more than 95 percent of the costs of net uncompensated services. to uninsured indigent patients as defined in 2. above for the state fiscal year which ended prior to the beginning of the federal fiscal year and will be paid in the second quarter of each federal fiscal year. The combined appropriated Medicaid disproportionate share hospital payments funding plan shall be prorated between the facilities based on total costs of uncompensated services delivered to uninsured indigent patients as computed above.

b. The final installment will be paid within 120 days after the end of the federal fiscal year, and will be charged against the annual federal allotment for disproportionate share adjustment payments for the prior federal fiscal year as provided in federal regulations. This final installment will be equal to the lesser of; (A) the residual of costs of uncompensated services delivered to uninsured indigent patients for each facility after subtraction of the initial installment paid under a. above for the state fiscal year that ended prior to the beginning of the federal fiscal year, or;

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E. DISPROPORTIONATE SHARE PAYMENTS (cont.)

(B) the residual of the remaining balance in the federal allotment for state disproportionate share adjustment payments for the fiscal year, after subtraction from the federal allotment, (i), the initial installment payments paid under a. above and, (ii), disproportionate share payments made under terms of Part I of this plan attachment. In the event the final installment adjustment payment is limited by the residual of the federal allotment, the payment will be apportioned between the facilities based on the ratio of the facilities' initial installment payment.

F. CUSTOMARY CHARGE PAYMENT LIMITS

As required by 42 CFR 447.271(4) total Medicaid payments to each hospital for inpatient hospital services to Medicaid recipients shall not exceed the hospital's customary charges to the general public for the services. The state may recoup amounts of total Medicaid payments in excess of such charges.

As permitted by 42 CFR 447.271(b) customary charge limitations will not apply to public providers who provide services at a nominal charge.

G. ADMINISTRATIVE POLICIES

1. Provider Appeal Procedures

State psychiatric hospitals appeal all Medicare cost controversies within applicable Medicare appeal procedures. All results of these appeals will be processed within the Medicaid reimbursement method as provided under Retrospective Cost Reimbursement Method above.

2. Uniform Cost Reporting Requirements

State psychiatric hospitals are required to complete and submit a copy of their annual Medicare cost reports (HCFA 2552). In addition, these hospitals are required to submit other financial information as required by the MHD.

3. Financial Audit Requirements

State psychiatric hospital Medicare cost reports and accounting records are subject to audit by: (i) the Medicare intermediary, (ii) the Washington State Auditor, and (iii) the Internal Auditor of the Department.

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DISPROPORTIONATE SHARE HOSPITAL PAYMENTS - STATE PSYCHIATRIC HOSPITALS, STATISTICAL SAMPLING PLAN

Purpose: Using statistical means described in this sampling plan the Mental Health Division (MHD) will measure the net uncompensated costs of services delivered to uninsured indigent patients of state owned psychiatric hospitals. The resulting value will be paid as Medicaid Disproportionate Share Hospital payments to the hospitals.

Sampling Theory: Variables Estimation Sampling as implemented with computer software devised by U.S. Department of Health and Human Services, Office of Inspector General, Office of Audit Services. This software is named "RAT-STATS."

A thorough discussion of Variables Estimation Sampling is found in Sampling Methods for Auditors, an Advanced Treatment; by Herbert Arkin 1982, McGraw-Hill.

Definitions

Institutions of Universe:
Eastern and Western-State Hospitals are the topic of the sampled universe and will be treated as individual estimation entities under this sampling plan.

Potentially Uninsured Patients (PUP):
PUP are all patients in the psychiatric hospitals between the ages of 21 and 65. Patients in other age groups are considered to be potentially insured through operation of the federal medical programs of Medicare and Medicaid.

Sample period:
Each fiscal year beginning on July 1 and ending on the subsequent June 30 of the following year is a separate sample period.

Sample unit:
Each separate psychiatric hospital inpatient day of PUP is the sample unit. The sample unit is abbreviated as PUPD. The cost of each PUPD is the per diem computed by dividing total days into total costs. The net cost of a PUPD is the per diem minus all revenue attributable to that day.

Hospital stay:
All the PUPD are confined within PUP hospital stays. A hospital stay is defined as one or more consecutive inpatient days (count day of admission but not day of release). The stay begins with the first day of the fiscal year if the patient was in residence on the last day of the prior fiscal year, or it begins with the first day the patient becomes age 22 if the patient was in residence on the last day they were age 21 or it begins with the day of admission.

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DISPROPORTIONATE SHARE HOSPITAL PAYMENTS - STATE PSYCHIATRIC HOSPITALS, STATISTICAL SAMPLING PLAN (cont.)

Definitions (cont.)

The stay ends with the last day of the fiscal year if the patient was in residence on the first day of the following fiscal year, or it ends with the last day the patient was aged 64 if they were in residence on the first day they became aged 65, or it ends when the patient is released for any reason and is not in residence at the midnight census.

Sample Population (also Sample Universe):
The sample universe or population is the total of PUPDs in each hospital for a fiscal year.

Population Array:
The purpose of the population array is to arrange the universe in such a fashion that any natural biases are removed. To this end the array will be fashioned in a two-step process. In step one, each PUP stay will be arranged in an ascending hierarchy by three orders of sort. The first sort level will be the PUP stay date of admission for the stay, the next sort criteria will be the date of release (if patient still in residence when population is identified the date of computer run will be last day for array purposes), and the final sort will the alphabetical sort of PUP names. In the second step, each day in each stay beginning with the first day of the first stay arranged in step 1 and ending with the last day of the last stay will be assigned a consecutive population number, beginning with number 1. As test of accuracy the total days in the stays listed in step 1 will be compared to the final population day consecutive number in step 2. They should be the same.

Sample Selection:
Samples will be selected randomly with FIAT-STATS random number generator.

Sample size:
Samples will be selected to a 95% confidence level with RAT-STATS.

Countable revenue:
Countable revenue will be all revenue received from or on behalf of each PUPD. In event revenue is received that is not identified to specific days, it will be prorated by the number of days in the stay. If payments are encountered that cover more than one stay it will be prorated over the days reported in the payment document.

Sampling Process:

The universe will be devised with computer capabilities from MHD database of all PUP having hospital stays in each hospital. The universe will be arrayed and numbered with sample numbers as described in definitions above. RAT-STATS random number generator will be used to select 500 samples.

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DISPROPORTIONATE SHARE HOSPITAL PAYMENTS - STATE PSYCHIATRIC HOSPITALS, STATISTICAL SAMPLING PLAN (cont.)

Sampling Process (cont.)

A pre-sample will be the first 50 random selections. The pre-sample will be reviewed for PUPD net uncompensated costs as defined below and is results will be processed through RAT-STATS to compute a standard deviation. The pre-sample standard deviation will be used in RAT-STATS to identify a sample size at the 95o confidence level. Additional samples will be selected from the 500 random samples in sequential order from the pre-sample end point to be added to the pre-sample to reach the computed 95% sample size. The added samples will be reviewed as described below. Each sample will show:

a.	Sample number	b.	Sample service date (sample unit)
c.	Patient record number	d.	Patient name
e.	Admission date	f.	Release date
g.	Stay from date	h.	Stay to date
i.	Days of stay		

Review process:

All selected samples will be reviewed for patient revenue by OFR and revenue will be reported for each sampled PUPD as either i. insurance proceeds or ii. all other revenue.

Estimation computation:

Costs for each selected sample unit (PUPD) will be the per diem for the hospital attributable to the reimbursement year. The total countable revenue for each PUPD will be subtracted from the per diem to compute net uncompensated costs of each PUPD.

The net uncompensated costs of all sampled PUPDs will be accumulated and divided by the total units or the sample to compute the mean PUPD sample value of net uncompensated costs of services to uninsured patients. The mean hospital PUPD sample value will be multiplied by the grand total of PUPD in the universe to compute mid-point of the estimation range.

Estimation evaluation:

The detail of estimation computation will be examined by RAT-STATS to compute upper and lower estimation amounts at the 95% confidence level. If the resulting estimation precision is greater than 10% of the mid-point, additional samples will be selected and reviewed in 25% increments of the 95% confidence level sample size until the original sample size has been doubled. If at that point, the estimation precision remains above 10%, the mid-point of the estimate will become the final value for purposes of the goal.

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DISPROPORTIONATE SHARE HOSPITAL PAYMENTS - STATE PSYCHIATRIC HOSPITALS, STATISTICAL SAMPLING PLAN (cont.)

Estimation Evaluation (cont.)

The net costs of uncompensated services delivered to uninsured patients at Western State Hospital (WSH) is predicted to be $75 million and Eastern State Hospital (ESH) is assumed to be about 1/3 of Western's value.

Both hospitals have average occupancy of over 90%.

The average length of stay in each hospital will be over 90 days.

WSH is predicted to have about 150,000 PUPDs (sample units) and ESH is predicted to have 65000 PUPDs.

ESH and WSH are separate Medicaid providers, with different per diem rates, necessitating separate sample entities.

The federal Medicaid DSH allotment for F/Y 95 will be low enough that the 200% transition factor will cause costs to exceed the limit, thus some of the transition costs and sample estimation at midpoint will not be needed to achieve the federal ceiling.

Patients in rare cases receive large payments (tort recoveries, retroactive insurance payments, estate settlements, etc.) that will exceed the cost of the stay being sampled. The value above 100% of the costs of the sample PUPD will be assumed to belong to stays and days outside the sample and excluded from the estimation computations.

Crude estimates predict that about 60% of PUP have no insurance or other resources, about 30% of the PUP have minor insurance coverage, about 2% have significant insurance resources, and the remainder require review of patient documentation on an individual basis to determine insurance status.

The federal medical programs of Medicare and Medicaid operate to fully cover costs of patients eligible for both. Patients eligible for only Medicare will be fully insured to the extent that they have not reached a spell of illness limit or lifetime inpatient psychiatric limits. Most Medicare only patients have achieved one of these limits due to the nature of their illness as reflected in the extended average length of stay.

If the PUPD revenue records are reviewed 6 months or more after the end of the sample period, it can be assumed that no significant revenue receivables exist, and that no significant revenue reversals remain unprocessed.